Information Exchange Workgroup
Draft Transcript
January 13, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Information Exchange Workgroup. This is a Federal Advisory Committee and there will be opportunity at the end of the call for the public to make comment. Just a reminder to workgroup members to please identify yourselves when speaking.

There's just been a slight change in the agenda. We'll have the PCAST discussion and then the briefing from the HIT Standards Committee and the ILPD discussion.

Let's do a quick rollcall. Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Hello. Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Connie Delaney?

Connie Delaney – University of Minnesota School of Nursing – Dean
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Carl Dvorak?

Carl Dvorak – Epic Systems – EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Gayle Harrell? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Charles Kennedy? Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Dave Goetz? Micky Tripathi I don't think is joining today. David Lansky? Steven Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy? Jim Beuhler could not make it. Walter Suarez? David Ross can't make it either. Hunt Blair?

Hunt Blair – OVHA – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Oestreich? Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay. With that, I'll turn it over to Jonah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good morning, everyone. Thank you, Judy. Welcome to the Health IT Policy Committee Information Exchange Workgroup. I am neither Micky Tripathi, nor David Lansky; I'd be honored to be confused with either of those two, but both of them were, unfortunately, unable to join today and are engaged in some other activities. They asked me to help lead us through the call today and I will endeavor to do my best to match their leadership and oversight abilities.

As Judy mentioned, we have a fairly full agenda today. We're going to start with the PCAST discussion and Paul Egerman is going to lead us through that. As most of you, I'm sure know, the President's Council of Advisors on Science and Technology released a report on health IT and had some very interesting recommendations for the nation, for ONC and some suggestions as to how they would recommend developing a health information technology infrastructure and framework. I think we'll hear from Paul today, who will, I believe, summarize some of those reports and I think we'll have a really good discussion about what are the implications for the work that we do.

We're going to also briefly provide an update on the presentation yesterday to the Health IT Standards Committee. If you recall, back in December at our last meeting we provided the recommendations to this workgroup, which then went to the Policy Committee and subsequently yesterday, a set of recommendations were made to the Standards Committee, so we'll hear a little bit about that. I was on for most of that call, but not the end. I, unfortunately, had to leave, so if others have thoughts and participated in the full duration of the call we'd appreciate your insights. I did get some notes from both Walter and Micky, who were participating. Walter, obviously, is a member of the Standards Committee.

We're then going to do some review of the Provider Directory Task Force framework and the work plan for the ILPD. What we did is we developed a couple of straw model use cases at our last meeting on the 4th I think it was of the task force. It was recommended that we continue with the process that was begun with the ELPD, where we defined a set of use cases for that any level provider directory to help guide our thinking in the development of recommendations. So it was strongly advocated that we do that now at the onset so that we all have a common grounding of what it is we're really talking about, because it did take us some time to really narrow this down during the ELPD discussion for those who were on the task force. I think we'd all appreciate being able to do that early and have a very common understanding of what it is that we are trying to make recommendations about. Then we'll talk about next steps.

Before we go through with the PCAST discussion and turn it over to Paul, any other general updates or additions or comments regarding the agenda? Okay. Hearing none, Paul, I'm going to turn it over to you. I think you have control of the Webinar, so I'm going to turn it over to you for the PCAST discussion.

Paul Egerman – Software Entrepreneur

Thank you very much. I'm speaking to you from just outside of Boston where it's the day after a blizzard. There's about a foot and a half of snow on the trees and it's a bright sun and it's beautiful, actually, outside. It's a little bit cold.

PCAST: As was just said, PCAST is the President's Council of Advisors on Science and Technology and it is a Federal Advisory Committee, an FACA Committee, much like our Policy Committee and Standards Committee, except that PCAST gives its advice to the White House and the PCAST Committee consists of a number of very distinguished members. Of course, the Policy and Standards Committees also are very distinguished, but in PCAST, you have a number of Nobel laureates and also a sort of broad range of science and technology experts. PCAST does provide recommendations on a broad range of science and technology subjects.

In early December—I think December 7th or December 9th—I can't remember; PCAST created a report about 100 pages long on HIT, on health information technology. I was asked to very briefly summarize the report. Unfortunately, I didn't have time to put together any slides on the summary, but even to summarize the report I feel like it's sort of like being a little bit on thin ice. Everybody who reads the report comes away with some slightly different impressions of the report, even though there's a summary, an executive summary in the beginning and also an excellent summary of recommendations at the end. So I'll give you my impressions of the report and those of you who've read the report can give their own interpretations, which, as I say, different people see it a little bit differently.

One interpretation that I have of this report is that there is a clear recommendation to increase the priority or the importance that is placed on interoperability; that is sort of this is something that is really an important aspect of what is happening. It discusses something called the network effect; that if we could do a great job with interoperability that would help speed the deployment of these systems. It might also create increased innovation, so there is emphasis on priority for interoperability. It describes, at least in very general terms, some methodologies. It says that there should be a universal exchange language. This universal exchange language that it describes is based upon ... metadata, so basically they're saying an XML style approach with tagged metadata that allows discreet data elements to be transferred.

Then it also makes related to that a series of infrastructure suggestions, so some of these are sort of like foundational things, like encryption and security issues. The one that is most or particularly noteworthy, not necessarily most noteworthy, but particularly noteworthy is a concept that's called a DEAS, which stands for Data Element Access Service; but basically it's intended to be a state-wide or regional index of every data element. Basically, it's an index that sort of says for this particular data element example that's given in the report is mammograms and it says, "For this particular data element here is the pointer that tells you where you could actually retrieve the mammograms."

The DEAS is really an index of like pointers that sort of says the location or the provider or the computer where that material is obtained. So that the DEAS operates almost like a search engine kind of a concept where in the example an individual clinician goes to the DEAS and can determine all of the different places where a patient's mammograms might be and can then, in turn, go to those locations and retrieve them. So again, the sense is increased priority or interoperability; this universal exchange language; the DEAS. There is a whole series of other important comments and recommendations in the report. It ends by saying something like this needs to be done by 2013, so kind of some fairly bold goals.

Then I want to talk a little bit about ONC's response to the report. Before I pause I also wanted to say what I have said so far really relates to ONC. The report also has some comments about other things, specifically some recommendations about CMS and CMS' computers, which I'm not addressing in this summary, but that's also an important part of their report. But I want to talk about also a little bit about ONC's response to that and there is a new workgroup that's been formed. But first let me pause and see if there is anybody, who has gone through the report and wants to either augment or change what I've said or disagree with what I said in terms of their interpretation of what the report says.

Carl Dvorak – Epic Systems – EVP
I've read through it and a couple of different rounds of other people's summaries on it and I think that's fairly succinctly put.

Paul Egerman – Software Entrepreneur
Well, thank you. Carl, you were one of the experts who gave testimony. Your name is there in the—

Carl Dvorak – Epic Systems – EVP
Yes. Don't assume that means I agree with it though.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I just think, as we've been trying at ONC, understanding this isn't our report; it's the report coming out of this other workgroup; one of the things that's been really helpful in our discussions is thinking about the different components of the recommendations. One would be around metadata tagging itself and enabling that. There's already, obviously, a lot of metadata that's being recorded and several standards incorporate that, but one would be simply where we are on the concept of metadata tagging.

Another would be the concept of a universal exchange language. A third would be the DEAS itself, which we're thinking of as sort of a ROF on steroids, an ROF—

Judy Sparrow – Office of the National Coordinator – Executive Director
At a data element level.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
—at a data element level.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So I just think it's one of the things that's been very disciplining for us is to not necessarily think of all of those at once, but to think about, A, the usefulness and, B, where we are in health IT and health information exchange on each of those. What it would take and what it would mean and what it would deliver in value to make progress in each of those flows. They don't necessarily all have to be packaged together. So that's just one thing that could be great to get folks' feedback on in thinking about, but that's been really helpful to us as we've looked at the recommendations.

Carl Dvorak – Epic Systems – EVP

I think one other concept that needs to be dealt with—I think this is a miss on the PCAST summary side and I think it may be even a miss on ONC's side at this point—and that is the language of the report itself needs to be refined a bit. I think the notion of a data element is used with such a broad range in this report that I think it leads to more confusion. Paul, I'm sure you know this having worked with radiology systems before, the notion of a mammogram result being a data element; a mammogram result is actually composed of hundreds of data elements—

Paul Egerman – Software Entrepreneur
Yes.

Carl Dvorak – Epic Systems – EVP
So I think there's even a language barrier built right into the PCAST report and it's generating a lot of confusion in the summaries that I read.

Paul Egerman – Software Entrepreneur
That's a good point that the PCAST Report appears to me to have been written by somebody who is not within the HIT industry and so because of that—

Carl Dvorak – Epic Systems – EVP
Agreed.

Paul Egerman – Software Entrepreneur
—it's sort of you have to be very careful, because it uses words differently than we understand them. So the comment that you just made, Carl, is really critically important because it talks about data elements and that actually—I once ... this ... that data is plural, datum is singular—

W
Yes.

Paul Egerman – Software Entrepreneur
But it does talk about it in the sense that when I read it I assumed it meant a very discreet, like atomic level datum. As a programmer, the thing that you learn is that X equals something. That's the way I understood it. I'm going to talk a minute about the workgroup and I have a wonderful Co-Chair, William Stead, Dr. Bill Stead, from Vanderbilt. I was talking to him about the report and he said to me something like, "Well, you know, you're a programmer and that's what you think it means when it says data or datum," but maybe, if I could use the example of something single, like a tetanus immunization, maybe that's a data element.

W
Yes.

Paul Egerman – Software Entrepreneur
Maybe a data element is immunizations. Maybe it's at a higher level than you're thinking about it. It's one of the reasons why, as I said when I described my summary, I was almost like nervous describing it, because I read it from that perspective. That may have been the same perspective, for example, that you, Carl, read it is if you've ever developed one of these systems you have one impression of what it means when somebody says data. Maybe that's not exactly what they meant. It's hard to know, so there is some interesting discussions that are to be held about this.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think I would argue that the report is ambiguous and that it's our job to interpret it logically in a way that brings the nation forward. I think—

Deven McGraw – Center for Democracy & Technology – Director

I agree, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
—that's what we should do. I mean if you look at how they were going to benefit from these data elements, they're acting as if we're actually encoding every little fact in a visit note, but in fact, we know that's not feasible. In some of their examples give a mammogram report as the chunk, so I think we just sit here and figure out, okay, we definitely want to move it a step forward. I have no objections to moving forward ... to an HIE. Let's just see what that means for us—

Paul Egerman – Software Entrepreneur
Well, that's exactly right and that's a good segue—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
....

Paul Egerman – Software Entrepreneur
That's a good segue to talk about what this workgroup is that's been established. A new workgroup has been established. It's called, I guess, the PCAST Report Workgroup. I'm the Chair—

W
That's too clever, Paul.

Paul Egerman – Software Entrepreneur
I'm not sure what the name of it is. I'm the Chair. Bill Stead is a Co-Chair. We have a great group of people. There is overlap between the PCAST Report Workgroup and this group, Information Exchange. There is overlap with a number of the other workgroups.

What our charge is, to be very clear, what our charge is is basically, what is being suggested here. Our charge is, first, to try to understand what the report says, but then to sort of think through what the implications are for all of ONC's programs and its fundamental strategies and also to provide a set of options or alternatives that ONC has to implement the report. In doing that, what we're trying to do is we're trying not to like judge the report. We're not saying this is right or wrong. What we're trying to do is sort of say sometimes it may seem like putting a square peg into a round hole, but this is what the report is saying. This is where we understand ONC to be. Here is how we understand what the implication of the report is. So that's what we're trying to do and we're trying to do it within a very tight time frame. Our complete recommendation is due for the April Policy Committee meeting and that's like approximately three months away, so it's a lot to absorb in a rapid manner.

If you're not a member of the PCAST Report Workgroup, I would tell you also that we are having our second meeting tomorrow, Friday, at 2:00. The first meeting was like we just spent an hour and tried to make sure we understood our charge and introduced ourselves to each other. The reason I'm bringing forward the comment about 2:00 tomorrow, at 2:00 tomorrow we're going to have Bill Press, who is the Vice-Chair of PCAST, come and he's going to present the report and give us a chance to ask him questions, which should be interesting.

Then after that Bill Stead and I are going to walk ourselves through some work cases where we're going to do our best to explain to the group the difference between what stage one meaningful use does with like a CCD and CCR and what the report is suggesting and to try to raise some of these very issues about what does it mean when it talks about data elements. How granular is that and how does that impact things? So that might be interesting for people to attend if you have opportunity to listen in. I think the first hour with Bill Press will be particularly interesting. This group may get a little less out of the second hour, because when you try to explain to people what XML is I think people probably in this group have a sense of that also, but maybe not.

The other thing that is going on is what you see on your screen. That second bullet is what I just talked about, the workgroup being formed. It says to provide recommendations o the report on the screen. That's actually not right. Our workgroup will not make any recommendations. We're simply going to discuss the implications and show what options exist. I mean the charge that came from David Blumenthal was we're not criticizing or praising the report. We're simply trying to understand it and show how ONC might implement it.

The first bullet says, "ONC is seeking public comment until January 17th on a set of questions," so one of the things that we will be doing is working with ONC to read through all of the public comment. Plus, we will be holding hearings on a date to be determined. It will probably be either February 15th, 16th or 17th. So we will be asking for comments from privacy advocates and from vendors and from other interesting people. We will be listening very carefully to those comments.

The next couple of slides I'm going to walk through quickly are the questions that ONC is asking public comment on, but I want to be clear; we're not asking this workgroup to answer the questions. However, if you work for an organization, including an HIE, it would be completely appropriate for you, either individually or as your organization, to respond. This thing started in December and over the holidays, people may not be as focused on this as they should have been focused, so these are the questions.

Here is the list of members of the PCAST Workgroup. Again, you can see that there is some overlap, I think, with this group. You've got Steve Stack and Hunt Blair are on both groups. Overlap with the Privacy Group, you see Dixie Baker from the Privacy Group. So there is a lot of overlap and certainly, overlap with the Standards Committee.

This is the list of RFI questions. I'm not going to walk you through all of those except to say, to repeat, as I said before, these are important and helpful if individuals or your organizations respond. I know you've got only like four or five days left to do that, but it's one of these things you have to respond at, what, I think it's Regulation.gov. It's in the Federal Register how you respond. That's very important to get that information to make sure that that's part of the entire feedback process. You see there's a fair amount of questions that are being asked here.

Let me pause and see if there are any questions for me or if Claudia or anybody else thinks that this is a pretty complete discussion. Do you have anything that you would like to add?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Just the observation that I've listened in on this group without saying much for months now as we discussed provider directories and the complexities and the challenges and when I read that PCAST Report it almost makes it sound—I'm going to be overly simplistic here—but the Internet is this amazing thing. This XML language is like the Rosetta Stone that unlocks everything and it is omnipotent and it can be adapted and extended and adjusted without limit and it will solve all of these things. So I'm looking forward to that discussion, the discussion we have in the PCAST Group. I may speak up a little more to ask questions, because I assume that this all makes sense to people, who do programming and technology stuff, but it just almost seems like too much of a ready-made panacea. It seemed anything but simple as we've discussed just the facet of provider directories over the last few months.

Paul Egerman – Software Entrepreneur
Well, that is a great observation. As you make that observation, I'm sort of smiling, because, as I say, we all approach these issues from different perspectives. As a vendor, I'm accustomed to standing in front of a group of people and saying that my technology will save the world and do absolutely everything and I'm accustomed to physicians sitting and listening to my presentation and being highly skeptical. So what you just said—

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A very politic way to put it, Paul.

Paul Egerman – Software Entrepreneur
—is very healthy as part of the process.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thank you, Paul.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Paul, I'm wondering if you had any thoughts on the DEAS (the Data Element Access Service), and the link between the universal exchange language. Are we assuming—or maybe we shouldn't assume anything—but is there some opportunity for this Data Element Access Service to be standardized across regions, states, the country? Would it look something potentially like a set of common medical terminologies and pointers to sources of information? I'm just trying to really understand what the DEAS, how it's been conceptualized and after reading the report I don't know—

Paul Egerman – Software Entrepreneur
Well, Jonah, that's like a wonderful question. The report is very high level and conceptual and so there are a lot of opportunities to decide how to implement the report. In fact, it says that in the report. It doesn't really prescribe or proscribe or whatever the right word is. It's specifically how you implement a lot of things. It just says these are the concepts and you should implement it however makes sense.

It does suggest that for the DEAS that there needs to be some sort of uniformity in the implementation for it to work correctly. To understand the DEAS in the context of the HIE organizations that are set up is also an interesting thing to consider, but I don't have any answers to the question as to how it's actually going to work. I mean that's going to be within the scope a little bit of what the workgroup is going to do, although the workgroup would probably say somebody has got to figure that out.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Paul Egerman – Software Entrepreneur
So in terms of the policy, I don't think the workgroup is going to say this is how to do it. It's going to make an observation that, "Gee, this is something that needs to be figured out." But again, I can't predict how any workgroup is going to actually proceed. It's certainly an open question.

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So, Paul, I mean one possible interpretation of the DEAS is that individual level metadata that allows for granular search. Let's say the examples in the report were things like looking for somebody's test results only, not their full CCD or CCR. One of the interesting and key questions would then be how much of the underlying actual results and data in the EHR or wherever the data might be stored would be necessary to allow for that kind of granular query. So I think you're absolutely right that it's not clear, but I think one potential interpretation is a vast amount of metadata at an individual level in order to enable the kind of functionality that they describe. So we'll really look forward to you guys kind of thinking about that; what the implications are of those different interpretations of what's in the DEAS.

Paul Egerman – Software Entrepreneur
That's right. So another way also to consider this is if anybody has ever read Latanya Sweeney's articles about information exchange or heard her comments at the Policy Committee. She was also sort of pushing that ONC establish an architecture for information exchange. What this PCAST Report does is it does recommend an architecture and Latanya called it in her article the heavy data architecture. She actually listed this as one of the options, so this is what she calls heavy data.

The report itself, as I say, it's about 100 pages long. I was informed that President Obama has read the entire report and so I figure if he has time to read the report we all have time to read the report, although it

occurs to me he has a bigger staff than we have. But still, if he's read the report I think we can all read it. If you haven't read it yet I would tell you not to rely on my summary or any of the summaries you see on the Internet and that you ought to read it yourself. I want to really encourage everybody to read it. You probably ought to read it twice. I mean I read it. When you read it there's a fair amount in the beginning that talks about the importance of HIT and so for us that's like preaching to the choir. We don't necessarily need to know that, but you've really got to read through this thing very carefully, because I think that's really extremely important for this workgroup to do.

The direction from David Blumenthal is in terms of coordinating from the workgroups or the comments from the workgroups, he would like that all to be coordinated through this PCAST Report Workgroup. So if you go through it any point and you start to come up with the understandings of the implications for any of the work that's already occurred, the best way to handle that would be to feed that through to me and Bill Stead. We'd be certainly very interested if, as a workgroup, you have some sense that this has some implication for something. I don't know what it is, but that would be helpful.

W
Yes.

Paul Egerman – Software Entrepreneur
But again, I really want to encourage everyone to read the report yourselves. Form your own opinions on it. Realize this is really an exciting opportunity. I mean it's just an exciting opportunity for us to think through what these issues are. You've got to read through some things that you may be skeptical about and try to see how we could take advantage of the opportunities that are presented.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
It strikes me that this is kind of an opening or the opportunity is really the opening and the elevated importance of this particular issue and sort of part of the national agenda.

Paul Egerman – Software Entrepreneur
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Given that we have a report that has been read by the president that really stresses the need to have a common language for exchanging information and really also suggesting, per my read of it anyway, that there needs to be more emphasis on secure, clinical exchange and granularity for how that information is shared or not shared in some cases, I think is part of the opportunity, Paul, that you mentioned.

I think one other thing—maybe this is putting Claudia a little bit more on the spot, if it is I apologize, but I'm going to do it anyway. The opportunity I think in the report is that it does sort of paint this picture, panacea or otherwise, of how exchange can be carried out in a much more robust way. It is, as Paul mentioned, somewhat conceptual. It's not specifically saying this is exactly how it should be done. The PCAST Workgroup is not making specific recommendations of how it should be done. I think where I'm going to put you on the spot, Claudia, a little bit is if we have this opportunity, whether you think it's real or not—no you, but the population in general—we have this opportunity with this report and this spotlight on this issue where we have a workgroup that is essentially interpreting, but not making recommendations for implementation. What potentially is the opportunity to the community to make the recommendations if we see they are appropriate and real so that we actually can, for example, consider integrating some of these suggestions into meaningful use criteria, stage two or stage three?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Well, first of all, if that's putting me on the spot, you're a very nice man, Jonah. I mean I guess this is also really useful to me because I wasn't able to join that first call. I guess I hadn't yet realized—I thought, Paul, you guys would be certainly interpreting, but also laying out the implications for ONC and for programmatic work that come a little bit closer to recommendations. Talk a little more about how that line

is being drawn, both by the discussion you've already had within the committee, but also by what guidance we've given you.

Paul Egerman – Software Entrepreneur
Well, the answer is, Claudia, I don't yet know how we're going to draw that line—

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Okay. So there might be a chance to—

Paul Egerman – Software Entrepreneur
But to do my best to respond to what Jonah is saying, there is an aspect of how ONC has responded to this that is like, in my opinion, almost classic David Blumenthal. This is like, to me, great leadership on the part of David Blumenthal. Basically, he is saying we've got this report. The first thing to do is let's go through it carefully and make sure we understand it, make sure we understand the implications and lay out what the options are. Then what we're going to do is make some decisions as to what we're going to do. I think this is really great leadership.

So, to respond to Jonah's question, I think we should just do exactly what is being suggested. First, let's read the report. Let's make sure we understand it, we think it through carefully. Once that's given an aggressive time frame, which is three months, but in a sense that's not all that long a time period. At the end of those three months then we'll be able to roll up our sleeves and everybody needs to start working together in whatever the plan is. I think it's just premature to like start implementing sections of it, but it's not premature to understand it and think through what are the possible implications of implementing.

Gayle Harrell – Florida – Former State Legislator
I was late getting on the meeting. I was in a hearing, but maybe this has already been addressed. If it has, please just give me a very brief synopsis, but if we're going to go into setting minimal standards for metadata for tagging it and if this is going to be truly the panacea for exchange; and this maybe is a question for Paul; do you see this really stifling innovation? I know if you're going to set certification standards on something like this we've been so careful not to try and stifle innovation. We've steered away from that whole realm of things, but what is your view on how this might, if you're going to go down that path and you think this is the panacea truly to establish, to really make interoperability happen? Is there the potential for stifling innovation?

Paul Egerman – Software Entrepreneur
Well, the best way I can answer that is I'd answer that similar to my answer. Whenever I want to argue for something, I always say if you do this, it will improve innovation. If I ever want to argue against something, I say if you do this, it will stifle innovation. So whether or not something increases innovation or stifles innovation, in my opinion, it's actually very hard to predict.

I will tell you that I did sit through for the last two days the Implementation Workgroup; the Standards Committee has an Implementation Workgroup that did hearings on what's happening so far with like stage one of meaningful use. There were a number of comments from people, who said something like this; they said we need standards. We need standards specifically around data elements and even a bad standard is better than no standard. We'll get more innovation if we have any standard at all. I don't know if people necessarily agree with that, but that was some feedback that we did get over the last day or day and a half.

So I guess my answer to your question, Gayle, is it's a good question, but it's not possible to give like an objective answer to that, as to what that will do. The report says that it will increase innovation. I think Steve Stack had some skepticism about the report itself. It's a great question ....

Gayle Harrell – Florida – Former State Legislator

It seems to me that they're setting this up as the panacea of how to make things happen and certainly, our Standards Committee has troubles with various issues. We in the Policy Committee have also struggled with many of these issues. It seems like all of the sudden we have the answer. Am I being a little naïve? I'm not—

Paul Egerman – Software Entrepreneur
No. I think that's a great question. I mean another way to look at it goes back to Carl Dvorak's comment about that's the definition of a data element. If you define it at an atomic level and you say it's like the lowest, discreet element, well, healthcare must have somewhere between 75,000 and 100,000 different data elements—

Gayle Harrell – Florida – Former State Legislator
Correct.

Paul Egerman – Software Entrepreneur
It's going to be pretty hard to establish standards for every one of those, especially when you realize that even a data element as seemingly simple as like date of birth, people can have a discussion like three or four hours about what the right standard is for just date of birth. So you start to multiply that by 75,000 data elements, you've got a lot of that, a lot for these teams to work on.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... and I think what these comments are super helpful on is to start to tease out implementation lists for the various things in the report.

Paul Egerman – Software Entrepreneur
That's right.

Gayle Harrell – Florida – Former State Legislator
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Yes. Claudia and Paul and Jonah, along those lines and keeping with the theme of potential opportunities and issues that are going to have to be drilled down into more carefully by the workgroups is the notion of sort of being able to exchange by searching for patient information. Versus some of the recommendations that we've developed on exchange that have really focused on sort of models where you know who the provider is that you want to exchange with. You know who the provider is who has the patient data you are seeking versus looking for it based on patient demographics. Master Patient Index, Record Locator Service, DEAS, whatever you want to call it, we haven't mined that territory at all.

Paul Egerman – Software Entrepreneur
That's right. So these are all excellent comments. As we have these discussions, in fact, as Claudia has said, it's just to tease out that there's a lot of very interesting issues and you're asking me a question, Gayle, and I'm not necessarily answering your question, but the reason I don't necessarily answer these questions is it's not like I'm trying to hide anything. It's because I don't think a lot of the answers are known yet, at least I don't know them. We're in the early part of a process. I hope you all individually, as I say, respond to the RFI questions. That would be extremely helpful, I think, to everybody. If you have comments and feedback as you read through the whole thing if you could just forward them to me that would also be helpful, although I'll be on your calls.

The most important thing that I do want to reiterate is be sure you read the whole thing. It's not a hard read. I know it looks like it's 100 pages long, but the fonts are pretty big and there are good margins, so you can go through it fast.

Claudia Williams – ONC – Acting Director, Office State & Community Programs

Would it be helpful, Paul, to walk through— I know people are probably at different pages of having read it or not, just to even spend some time today talking about some of the specific RFI questions with the group?

Paul Egerman – Software Entrepreneur
Pardon me?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Would it be helpful right now, and I apologize ..., to walk through the questions and actually have some discussion right now of some of those as a group?

Paul Egerman – Software Entrepreneur
That's up to the leaders of this workgroup. I mean they told me to talk for 20 minutes. I've already gone past that, so they're doing the agenda. What's important, Claudia, though is we're not asking the workgroup as a workgroup to respond to the questions.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Egerman – Software Entrepreneur
I mean I just want to make sure. These are questions for—

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I understand that. I just thought that people might learn something through—

Paul Egerman – Software Entrepreneur
—for individuals, but if people want to walk through them—

Claudia Williams – ONC – Acting Director, Office State & Community Programs
But I defer to all of you as the chairs.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Since our chairs aren't actually here and I'm de facto, what I'm going to do is just see whether or not members who are on the call today feel that it would be beneficial. On slide 7, you can see we've got some of the RFI questions to sort of walk through a few of these. We're not intending to enter recommendations here.

Deven McGraw – Center for Democracy & Technology – Director
Yes. Jonah, if we, as a Policy Committee, as workgroups of the Policy Committee, are not being asked to specifically address those questions and given that the comment period for those questions is expiring like Monday, I'm not sure that's a terribly useful use of our time.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Others? Speak up, please. I'd like to make sure we're moving forward appropriately.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can I ask a question of Paul? What's going to be the link between the PCAST Workgroup and the Information Exchange Workgroup? I ask because I'm on the Meaningful Use Workgroup and so obviously it's the efferent how does this information get from one to the other to the efferent arm where changes are supposed to occur in stage two.

Paul Egerman – Software Entrepreneur
Well again, what we're going to be doing is we're going to list a set of options and alternatives for ONC by mid April and this February there are going to be hearings and we're trying to coordinate them so that

they'll be possibly joint hearing that might include Standards Committee and Policy Committee also. So we're going to work really hard on getting everybody coordinated, but right now, as a result of PCAST, we're not asking the workgroups to do anything differently other than to be aware of it, to think about it.

Once we get to the April Policy Committee meeting, depending on what the alternatives come out with, that would be the point that there might be some impact on some of the workgroups; certainly, I would think of all of the workgroups the one that would be most effected would be this one eventually. The work that this workgroup is doing right now on provider directories strikes me as something that is still necessary. We might discover that it's even more necessary after April, but my initial blush on a lot of these things is that the work that was done on the enterprise level directory, the work is lose, is still critically important and maybe even more important based on what this report is saying.

M
I'll point out to people not in the loop that the Information Exchange, the Meaningful Use stage two request for comments, which was published yesterday I believe on the Web, it put CCD into 2013 as opposed to 2015, so not because of PCAST, but coincidentally it already heads in that direction. Previously it was just a text thing and now it's CCD in 2013, not for Information Exchange, but for sharing data with patients.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
So that's one of our first successes.

M
In terms of your question though, Jonah, again, regarding bridging workgroups, I think this is the question that we all struggle with, especially those that participate in multiple workgroups and try to see what the bigger picture looks like. I think what we got today is a really good summary from Paul Egerman as to what the PCAST Report is and what their workgroup is going to be doing. Given that we are fortunate to have Paul and a couple of others serving on both committees, we can request that they provide us with updates as they arise that are critical and use this time to share information.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Just from an ONC end, we definitely recognize that as we move forward the domains that we're dealing with from governance to PCAST to the Privacy and Security Tiger Team to our group, we really start to have some critical areas of overlap. I mean they probably always have, but as you did down into actually what you're going to say concretely they become more evident. So we've had conversations internally about whether it would be helpful to have a Chair Call Workgroup. Certainly, I think it's fabulous to use the overlap that naturally occurs and we encourage that to occur to brief each group on each other's work. That's a really helpful way to do it. I think we're also trying to consider at a staff level what we need to be doing to tease out some of those intersections. This is a broader issue of sort of the governance of our Policy Committee process. I've definitely talked to Micky about whether a chair's call, maybe monthly, would be helpful so we can anticipate where either we're going to need to respond to each other's recommendations or whether there is some overlap that needs to be considered in a more deliberate way.

Deven McGraw – Center for Democracy & Technology – Director
Claudia, That's a great idea. Some of us have actually been arguing for that for a while, but maybe this is a good organizing principle to push that forward.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think, Deven, you've been pushing for a chairs call as a specific mechanism?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Judy is the boss of all of us, so—

Deven McGraw – Center for Democracy & Technology – Director
I mean, pushing may be the wrong verb. I think a lot of us have suggested it would be good for us to be regularly coordinated. We've sort of done that in a de facto way through the overlap of membership, but a more organized sort of roadmap or discussion about how we're going to move forward and who's going to do what I think would be most welcome.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Great. I've already had informal conversations, but I'll take that forward more—

Deven McGraw – Center for Democracy & Technology – Director
Yes. Great.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
—more forcefully.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Perfect. Any other thoughts for Paul or for the group in general regarding PCAST Workgroup? Okay. Paul, I really appreciate you providing us an overview and helping informing this workgroup about the PCAST Report and the workgroup and I would also encourage those who have not read the report to read it. I agree with Paul. It's not a thick, heavy read. It's actually very readable and has some really interesting insights when you get into some of the details. The second on privacy and security, which I think is quite interesting as well, which we haven't talked quite as much about, but really does have implication potentially for all of us. Thank you, Paul.

Why don't we move on? If we can advance the slides just a bit, we're going to talk about the Standards Committee meeting that was hosted yesterday. I was able to join for a little bit of it. They were running over, so I unfortunately had some conflicts with some other meetings. I actually got almost all of Arien's very good discussion about the SNI framework, which was terrific and I got some of the report back into the Standards Committee on the work that we're doing. Micky and Walter also provided some insights, but if others were on the Standards call yesterday and were able to hear the whole thing I'd like to get your insights and make sure I'm not missing anything.

But the overall impressions that I got and I think that Micky and Walter also got is that the recommendations were well received. Again, these were recommendations that came out of this workgroup in December up to the Policy Committee and then over to the Standards Committee. Does anybody want me to just very quickly rehash what those recommendations are? Because I can pull that up and go over them. No.

W
Jonah, can I just ask you, we actually, in our internal conversations realize that while there's been a lot of shaping of standards work from the policy work there haven't been many cases of this actual data flow like we imagined it, where the Policy Committee keys things up informally and sends it over to the Standards Committee. So I'd just love to get your feedback on they seemed like they knew what to do with it and how to pass forward as far as how they would be considering that.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. That was my impression it was. We blazed the trail yesterday and I think it was welcomed and understood and well received that we have this process. We essentially are proposing this process and the result is from my hearing ... of the conversation yesterday was that the Standards Committee understood what it was being asked to do and was at a position of just deciding what workgroup within

the Standards Committee was going to respond to the recommendations and actually start working on the standards that were being requested of them.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, Jonah. That's right. There was also a suggestion that maybe a new workgroup be formed, incorporating some of the people from the other Standards Workgroup. That's an item that we need to discuss with the chairs.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay.

W
....

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good. So just to recap, well received; by most accounts the recommendations were understood. There was some questions. Wes Rishel, for example, was asking, as he always does, a very insightful question about operationalizing the directories, specifically asking who would be responsible for this and who would bear the burden of the cost, which I think is a very good question.

I don't know if we heard the question regarding maintenance of the national—in our recommendations we essentially said that we were going to have these regional—we recommended that there be these regional registrars that are able to issue some kind of a digital certificate. We didn't get into specifics, obviously, that's the Standards Committee work, but that there be some way for the registrars to be linked to a national repository or database that EHR vendors and others could access and update on a regular basis. I don't think I heard the question. I'm not sure we've had the discussion about whether and how and who supports and hosts that national repository, that database. Those who are more technically gifted than I am might have better answers to that and how it's done in other settings, but I don't think we heard that. Wes may have been asking this question specifically about that notion or about how the regional state HIEs or others are going to operationalize the ELPD. If other people, again, on our workgroup have any insights into that I'd like to hear your comments.

Then, as I mentioned, the Standards Committee is taking the recommendations and they'll be meeting with ONC leadership, as I understand it, to determine which of the workgroups is going to take the lead. I think Walter would like to see this happen under one of his workgroups in the Standards Committee, the Security and Privacy Workgroup. Which I think makes sense given that I believe that they're going to be addressing the standards issues around digital certificates and probably could address the relationship between the two, the recommendations that were made and what they've been asked to do, I think, understanding and defining what digital certificates are and how they're created.

Any others? I'm interested in hearing was anyone else from our workgroup on that call and have any specific thoughts or additions they want to add? Nobody else was on the call or no specific thoughts about this? Okay. Then I guess we're going to move forward.

In our last meeting of the task force, we proposed that we adopted the same framework that we adopted ultimately for the Entity Level Provider Directory in creating and proposing, recommending a set of requirements for the Individual Level Provider Directory. That being said, on slide 11 is the diagram that you've seen now many times that we go through a process of identifying the users and uses of an Individual Level Provider Directory. We actually have to define it and make sure that we all have a common understanding of what an ILPD is. That we define what the functions of that directory are, what kind of content should be potentially maintained and hosted in that directory, what kind of operational requirements the supporters and instantiators of those directories support and what are the possible business models for sustaining it and maintaining it in the long run.

We expect to have some support to ensure that we have an environmental scan and business analysis. I think a lot of that work has already been done. Given the hearing that we had last year, much of what we heard was information that was specific to the ILPDs, so we heard from Surescripts. We heard from Wisconsin and a number of others, who are maintaining Individual Provider Directories, so I think we have good information about what exists out there. We heard from CAQH. We heard from a number of others, who provided really excellent testimony to us.

Once we go through this directory requirements and options analysis, which we have a short timeline in which to do this, we would then make recommendations. We would sort of go through our consensus process and identify policy issues and specific policy actions that should be taken. It's pretty straightforward, essentially adopting the same principles and process that we did for ELPD and we ultimately adopted there. I think we would do this in the way that seemed to work best for us once we fully grasped what it was we were dealing with, because I think we were all grasping at the elephant, is develop some basic use cases so that we all can really understand how we're supposed to apply and use the ILPD.

Any thoughts or comments? Any feedback or thoughts about how we want to potentially proceed in a different way? If not, let's move to the next slide.

Our proposed work plan is aggressive. It reflects the nature of the times that we're in, but we are going to press to get this work done in the time we've described here on slide 12. Obviously, in the Provider Directory Task Force we went through that sort of framework and schedule, the schedule you see before you. Then we would begin to define these uses and use cases and describe functions that today we would essentially brief this workgroup on that framework and timeline and define some of those functions. We obviously discussed the PCAST Report.

I'm suggesting that today we actually go through some of the use cases so that we can begin to define the functions. I think it seems to me a little bit harder to define functions before you actually know how and what it is you're talking about and how it's supposed to be used. So that's what I'm going to be proposing that we do today. Again, this is where we really appreciate feedback from the workgroup.

In a week's time we would go back to the task force and we would present the framework, use cases and develop some definitions and specific functions and content and operating requirements for these directories. We could discuss potential business models, so clearly, that's a very busy two hours. We would spend a following week going through more of a business model discussion. Then once we have the uses and functions and content and business model recommendations we would then discuss the policy issues and actions that could be taken to promote the use of ILPD. Then we would approve recommendations. We would hope through this workgroup and then this workgroup would make recommendations for the Policy Committee.

That's our timeline. Completely realistic, I know; but this is obviously very important work. Part of this is obviously pressing on stage two and three meaningful use and that regulation all impending. Part of this, the urgency of this is really to help inform what's happening in many, many states. As we all know, many states are now going through the process of issuing RFPs, awarding RFPs, in some cases, already building directories of some form. It's very clear that we need to have some sort of a common framework to be able to support some kind of federation of these directories if at all possible. Given where I think we're leading towards, which is linking these to the Entity Level Provider Directories, it would be, I think, terrific if we can help guide the development of both of those so that we can have much more of a universal exchange language, to use the word of the day.

Any thoughts on the proposed work plan before we move forward?

Gayle Harrell – Florida – Former State Legislator

I'd like to comment that I think it's imperative that you do have this aggressive time frame. I was just in a committee hearing on—

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Gayle, I'm afraid you're breaking up. Can you please repeat if you're still there? Okay. Gayle, when you get back on, if you can still hear me, I'll ask if you can repeat that. Other thoughts before we move forward? Okay.

We've attempted to put down a few of our operating assumptions and framing for the Individual Level Provider Directory. We want to make sure that these seem appropriate and get your feedback on some of them. So the first set on slide 13 is that the scope of the Individual Level Provider Directories should be at a sub-national level. That means that they could be regional. They could be state-wide. They could be multi-state. But what's not being considered is that we have a national patient provider, individual provider directory service of some kind. If it happens that we can have, much like we recommended in the ELPD, some sort of a federation of sub-national directories I think that would be very helpful and very useful, but at this point we're assuming that we're not going to make recommendations, that there needs to be a national individual directory.

Kind of an important assumption: We heard this over and over again in our hearings that we shouldn't try to create that. We shouldn't make the recommendation that that is what we're going to build only because it is for those who have tried to maintain a local provider directory. Incredibly challenging. Once you even create it it's already out of date at a local level and a national level. It just increases the level of complexity by orders of magnitude.

At any point if you have any thoughts on these assumptions, please chime in.

A second assumption is that rigid conformance at a national level, the kinds of standards and policies that we had recommended exist in the ELPD and that are necessary are not necessary in this case. In the case of the Individual Level Provider Directory you don't need that level of reduced conformance because we're not talking about having it a strongly, highly federated model of interoperable directory services, much like we have in the Internet with a common directory or addressing schema. We're assuming that we're not going to have the same level of reduced conformance and that it will allow for regional variability. A lot of that, I believe, has to do with the fact that we already have many individual directories that are very different and we don't want to rebuild every one of them to conform to something or don't believe we can do that.

As I mentioned, another assumption is that states are implementing these as we speak, not only states, but private organizations whether they're health plans or networks. We need to produce recommendations rapidly so that there can be potentially best practices that those who are going out and actually beginning to build or modify can learn from best practices and support local ILPDs most effectively. Best practices for local policy levels for incentivizing; incenting is not a word; neither is incentivizing, but creating incentives for participation in ILPDs is something to consider here. Another thing is that we proposed, as I mentioned, using the framework for ELPDs that we do for ILPDs. We just went through that. I don't think there's any real controversy there.

We have a few more assumptions here before we move on to where we go. A few assumptions here are what would be in the ILPD is that the ILPD would list locations of individuals; they would have information about individual providers and their locations, specifically where they practice. The ILPD would have a many-to-many relationship with the ELPD and that there would actually exist a relationship between the ILPDs and ELPDs. Which means that if, for example, we have in some states or regions Entity Level Provider Directories an individual person or even a system, an EHR or otherwise, could link the whatever, the ELPD information they have to a local Individual Level Provider Directory to help with their human interaction when information about a provider where they practice is not known. Maintenance and updates of ILPDs would be managed at the local or regional level and not necessarily managed and

supported at the national level. Again, this goes back to not having this national database repository of individual providers.

The final assumption is that the primary value proposition is the exchange of clinical ... where providers have only basic information about other providers where a patient is seeking care and they need to locate those practices where the provider actually does their work and sees that patient.

So again, this is much more about the human-to-machine interaction where a patient is referred to a practice or a clinic or a hospital and the patient is making a request to see someone in particular and the provider may not know where they practice, so this is much more about the human factor. We're making this assumption and I would like to test this with you all. We're making an assumption that there is a human factor of a person not knowing exactly where the patient is supposed to go, but that there is a destination for that patient and information that needs to follow them through the EHR that they are using to an EHR that they are being referred to. That we're suggesting that there does need to be this linkage between that human interaction where they're looking up information about a provider and then the Entity Level Provider Directory where it's more the machine to machine communication.

So I hope I haven't thoroughly confused anybody, but I'd really like to stop there for a moment and get your thoughts about our assumptions.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Jonah, you get us to consensus faster than any other chair I've worked with.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I really appreciate that that is the conclusion you've made. Hearing nothing means either I've completely lost everybody or everyone is in complete agreement on where I've been, but I don't want to make the assumption that everyone is in complete agreement. I hope I haven't lost everybody, but—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I thought it was very clear.

Hunt Blair – OVHA – Deputy Director
Jonah, I'm in agreement with what you've outlined.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I think it was pretty complete, Jonah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Terrific. Okay. I feel better now. Let's move on to slide 15, please. What we've done here is sketched out two use cases. You know what? Before I do this, we lost Gayle. If you're back on or can hear us, we lost you and didn't hear your question about our timeline. Are you there? If you are, do you want to repeat your question? I think she's gone through a very long tunnel.

W
Is there a question for me?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think it was from Gayle. I think it was Gayle, who had a question about ten minutes ago. Okay. Then I'm going to move on.

What I've done here is set up a couple of test use cases. Again, this is to test flight the assumptions that we've made and specific uses that could be or demonstrate the value and help us articulate what it is that the ILPD actually is and will do and what value it could lend to improving communication among providers and dissemination of patient information across the care setting.

So I've done two basic use cases here. I'll start with the first one. The first one; the format here should look familiar, because this is one of the things we did with ELPDs thanks to Walter Suarez. The scenario here is that a patient summary is sent from a primary care physician to a specialist. Specifically the scenario is a primary care physician from Clinic X would like to send a patient summary document to a specialist in Clinic Y, but the primary care physician does not have sufficient information about the location, where the specialist practices, but may have some information about the specialist. So a patient presents, has a complication of some kind; needs to see a specialist; has someone in mind, either the provider or the patient do, but neither knows, has enough information about the actual practice setting of that specialist and Clinic X wants to be able to send a summary document to Clinic Y.

The scenario then would allow for the Clinic X to look up the physician and identify where that physician might practice, the specialist and then initiate the transaction that we've outlined in the ELPD discussion, where the actual location of the specialist in Clinic Y is identified, the right location. Then the transaction can begin, where by Clinic X send the patient summary. Digital certificates are reviewed by both sender and receiver, authenticated and verified and then there is a transaction once those conditions are met and the patient summary is sent from the primary care physician to the specialist and incorporated into the EHR.

The value of the Individual Level Directory is that, first of all, Clinic X doesn't know exactly where the particular specialist practices. They may not have enough information to even know what that practice is called or whether or not they practice in multiple settings. So they only know, they have much less information than even a partial address, a partial e-mail address, as we've been using the analogy in the ELPD discussion. They may only have a name.

Clinic X uses the Individual Level Physician Directory and this could be native in the EHR. This could be standalone. I think part of what we would want to do is recommend how these two things would interact. Clinic X would use the Individual Level Directory to look up potential locations and make sure they've identified the right specialists first of all and second of all, the specific location that that specialist is practicing, where the patient needs to go.

Then the ILPD would provide that listing of potential locations and allow the clinician or their administrative staff to identify the correct location, the correct address of that specialist's electronic health record so that the interaction that we've descried in the ELPD discussion can actually take place. The EHR of the primary care physician can then initiate the transaction, send the summary to the specialist. There can be that investigation and the verification of digital certificates and digital credentials and the computer transaction can be completed.

That is the scenario, number one, that I've described and some thoughts about the value of the Individual Level Directory. Does this align with thinking amongst workgroup members as to what the ILPD is, how it interacts with the ELPD and what value it potentially brings? I've done it again.

M
Yes. Feel validated, Jonah.

W
You did a great job.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Great.

W
But we will assure you that in the task force there will be a lot more discussion.

Paul Egerman – Software Entrepreneur
One question I have though as I look at this, would there be an alternate way to do this same thing? In other words, in this situation would they just go to the Internet or look at some other directory? Why would they necessarily use the ILPD to do this?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

W
I mean one thing that I think we've hinted at, but probably will return from this discussion is the idea of having some kind of authentication process, A, for not at the individual level, but for knowing that this a group of folks, who have current licenses, various other information about their practices. So I think that wouldn't necessarily be a characteristic across all ILPDs. I think the way a lot of folks; I'm thinking about the Wisconsin case where it is generated by the medical society; they use licensing information to validate the information. They have a process for being sure that the addressing information is correct. It provides a much more useful source than anything else that exists at the state level for sure. So I know we'll get into a lot of that as we discuss it, but I think that question of trusting, not trust at the level of individual authentication, trusting that this is the right practice that I want to send it to. They may have five locations. Is this the right one? That this person indeed is licensed; that it's okay to send it to them. That level of sort of trust in using the provider directory is something that might be afforded by the data elements and the verification process itself that the provider directory goes through.

Paul Egerman – Software Entrepreneur
Part of the response I'm hearing is that the reason that the ILPD would be used instead of other sources is because of the right word is it's authoritative or the quality of the source information.

Hunt Blair – OVHA – Deputy Director
Yes. Paul, I think authoritative is exactly the word. I mean for the same reason that lots of reference librarians caution against overuse of Wikipedia, I think the Internet itself can be complicated. Also just for ease of use, because if you Google a given doctor one of the things that you're going to get returned at this point are a whole lot of different sort of; freelance is not the right word, but marketplace solutions to providing directories of providers. There is a pretty variable level of authority to what's listed.

Gayle Harrell – Florida – Former State Legislator
I think who is going to authenticate, who is going to be in charge of the directory, who is going to authenticate and verify who that doctor is, that they're licensed and that this information is correct. There is a lot of question. As you said, there are all kinds of people out there running different directories, so how do you get to the appropriate directory?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. A lot of the analogy that I see is ... analogy. When we see what happens in basic work flow today we have a referral of this kind, let's just take this specific use case. By and large, you don't have an electronic directory of individual physicians that you would look up. You have a phone and you have a phone book or you have a piece of paper in the office that lists the fax number of the clinician and you send whatever information you need by fax.

I think where the value of this is—and it's a really important question, Paul—is are we proposing that an ILPD is going to have enough value that it is worth maintaining a potentially very large data repository of individual level providers that is authoritative enough. That is accurate enough and that reduces the workflow burden on the clinician and their staff to implement and use these directories when you could simply pick up a phone. Call the practice if you even know the phone number of it and if you don't have a fax number and get enough of that information just over a phone line and then deliver that information electronically using the ELPD. I think that's a really good question.

Paul Egerman – Software Entrepreneur
Right, it just strikes me as I read this scenario, I mean I agree with the scenario that would be a use for the ILPD, but also I think I bet the PCP has a process already in place to do this, right? That they do something. I don't know what it is.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Paul Egerman – Software Entrepreneur
That they have some directory, they do something. They Google. I don't know what they do, but the situation is a little different from the enterprise directory in the sense that there are sort of like possibly competitive approaches, which may not be as good, but it's just an observation.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes—

Tim Andrews
I think this is a good conversation and one that needs to be played out, but I will say there is often two things going on here. This is a really different medium and scales quite differently and so there are some qualitative differences that aren't easy to perceive when five people are exchanging records using EHRs as opposed to five million.

I think a lot of people have hit on it. One of the issues is ... and it's tied to policy, so it's not just technology. It's that there's a real problem, especially at scale if you start to think about a lot of these records flowing and sending records to the wrong place. Right now, there are processes in place. Actually, when you install an EHR usually the EHR is configured if there is going to be any exchange by the people installing the EHR. It's a technical thing and a ... thing. That can work okay, but I think you have to be careful of scale, particularly comparing the .... You can only take the metaphor so far. When you send an e-mail if it goes to the wrong place it's not the end of the world. If you start sending a lot of health information around any one record can always end up in the wrong place. It's usually not a complete disaster, but if you start talking about a lot of it, even a half a percent or a tenth of a percent can be a real problem. It's also tied to legal and liability issues.

My perception is the real value here if it's done well, if it's easy enough to use that is an issue. If it's authoritative, that is an issue. If it's tied to policy that says if you do it this way you won't be liable for the wrong information ending up in the wrong hands that really helps enhance interoperability. You've sort of got to think down the road a little bit about not what's happening now, but what would be happening when a lot of people are using this on a regular basis. I think actually machine-to-machine communications could take advantage of this as well. It could really scale up the number of transactions that would use these capabilities.

So yes, it works today because there isn't that much going on and because mistakes can be corrected fairly quickly and aren't that leveraged. The mistakes aren't that leveraged because they're contained, but if you start to get a lot of these things happening then even a small, tiny percentage of mistakes starts to become pretty significant.

Paul Egerman – Software Entrepreneur
Yes, I agree with that, Tim. I think maybe we have to assume a couple of more things. One is that we're operating in an ELPD environment where at least we would assume that there are far more providers who have electronic health records. They are actually being required through the meaningful use program to be exchanging information clinical, let's say a CCD, by 2013. We're not talking about text logs. We're actually talking about more structured data and that we have far more exchange of information on a day-to-day basis than we have today.

I think a second assumption might be that actually some of them are using ELPDs to do that. Then we have to consider if this is the environment in two years. It will simply increase as time goes on, as you mentioned, how critically important is it to have that level of authoritative assurance that you have some directory that is not going to lead to bad delivery to the wrong address and all of the implications and repercussions that that pertains. If there are a significant increase in the number of these transactions, as we anticipate, does the expected workflow impact to a practice, a clinic, a hospital not having a service that's much more tightly integrated with the ELPD? That allows for searchable, authoritative, identification of an individual level provider where they practice that is linked to their ELPD so that the workflow is minimize? It requires much less effort to pick up a phone, look up a source in some other directory somewhere that might have information that might be current.

I think we have to consider all of those in the discussions that we have, probably in the task force.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
It sounds like we're heading in the right direction. People agree that this is one of the use cases. On slide 16, there's a second use case. I'm actually not going to go through it, because I think we've road tested at least that this is kind of the right direction that we have to go in or that we should go in.

What I think I'm going to propose is that our task force—I'm going to give our task force our own homework assignment—build out a few additional use cases. I think we need to understand if we, for example, a use case is a query and response type of transaction where you may have information from the patient when they present about specific providers that they seek. That in that care setting they need to query a set of potential sources using a DEAS or using some sort of a record locator service.

What we'll do as our takeaway is I'm assuming we have a green light to continue pursuing as we're doing—please correct me if I'm wrong—but we will build up the use cases, create a set of proposed content, functions, business requirements essentially, operational requirements and some business needs. Over the next two weeks, as you see on slide 17, our task force will meet, review these cases and discuss these issues. We'll bring it back to this group—I think the schedule said at the end of the month—to validate that we are in the right direction and to make a set of recommendations that would go through this chain up to the Policy Committee and over to the Standards Committee if necessary for any standards work that needs to be done.

Any thoughts or comments first of all? It sounds like we're on the right track, but I wanted to make sure that we are before we bow out and make room for public comment. All right. I keep hitting them out of the ballpark apparently. Okay.

M
You're a slugger, Jonah. You're a slugger.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

W
Don't tell Micky and David. You might end up with a bigger job.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. No. I'm happy to fill in when I can and honored to do it, but this is one-time event I think. You may all be relieved by that. I think, Judy, we need to open up for public comment and then we'll close.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if anybody from the public wishes to comment? Also, let me say if anybody on the workgroup wants to listen in to that call tomorrow at 2:00, the PCAST, the dial-in is the same. It's 1-877-705-2976.

Operator
We do have a comment on the phone.

Judy Sparrow – Office of the National Coordinator – Executive Director
Would you please identify your name and your organization, please?

Morris Rang – Blessing Health System – Large Project Lead/HIE Coordinator
This is Morris Rang with Blessing Health System in Quincy, Illinois. First of all, I would like to compliment you on your work on your directories and the ELPD and the ILPD. It's been some great work. From your earlier discussion today, which you spent about 45 minutes on it was talking about the PCAST and I think really the bottom-line is that the report wants the ONC to place an emphasis on interoperability and that standardized language for exchange, which we need and we even heard that Tuesday from testimony.

The discussion, in terms of it would negate innovation I believe is just the opposite. I think if we had a standard universal exchange language, it would perpetuate innovation because with no standard we're more or less held hostage. This would more or less force the market to have some common ground, like other industries already have, because right now we are being held hostage by some of the vendors. Eventually then, I mean HIE is so important that down the line with the ACOs ... center, medical homes and things of that sort this is so critical at this time.

Lastly, Jonah, excellent facilitation today. Thank you.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Any other comments from the public?

Operator
Yes, we do have another comment.

Carol Bickford – ANA – Senior Policy Fellow
This is Carol Bickford at the American Nurses Association. It would be helpful for those of us who are coming into this work to have a clear understanding of what ILPD and ELPD are so that we understand the differences. Not having been privy to the conversation it's sort of like what is the difference and why are they segregated. I appreciate they have different concerns, but a provider means provider versus individual versus the enterprise level. So if you have an individual, who is in an individual practice is that also the enterprise? Just clarification as you're presenting this information would be helpful to reinforce the clear delineation of these two concepts. It's not evident.

Judy Sparrow – Office of the National Coordinator – Executive Director
Would anybody like to briefly summarize for Carol or no?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Carol, I really appreciate your comment. I'd also like to respond to Morris in a moment, the comment he made.

One of the things we did—and we certainly are glad that you're tracking this now—is we spent in previous discussions over the last four months or so, a lot of time actually figuring out what the differences were and were very intentional in dividing the enterprise level and individual level directories because specifically they have very different functions. We actually created a set of definitions that were attached to previous presentations and slide decks. What I think might be helpful is that we should probably

append to the deck that we present to the public those definitions and for each one of our presentations, to make sure that they're used as a reference so that people can track. I think we'll endeavor to do that.

Kory, if I can ask you to please help us make sure that we remember to do this whenever we are preparing these decks for these meetings?

I don't think what I'll do now is go into the definition, because it might take us about 15 minutes to do. I don't want to make any missteps in trying to define them; only to say that the enterprise level is really about an organization that has a specific either domain or URL or Web address or e-mail address and the individual physician and the directory would not necessarily have that. They might be associated with one or multiple entities. They may practice in multiple settings, so they may be a many-to-many relationship where one provider practices in multiple settings. But I'm not gong to get into more of the details, because I don't want to potentially confuse the issue. What we'll do is we'll make sure that we have the definitions posted so that you can look at them and we can make sure that those who are maybe not participating every week in these discussions can keep up when we start using our acronyms and our language.

Carol Bickford – ANA – Senior Policy Fellow
Thank you. That's very helpful. It clearly is not physician, correct?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
It's provider, Individual Provider Directory and specifically I think we're trying to use HIPAA definitions and the definitions that are being used across the different workgroups so that we are not across purposes or at least we're using the same language and reference.

Operator
We do not have any more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Thank you, Jonah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Thank you, everybody. I really appreciate your time. Paul, especially, thank you for the presentation; excellent presentation today on PCAST. I want to reaffirm his recommendation that you all read the report and 2:00 eastern time tomorrow I believe is when that workgroup will be convening. Apparently, in the first hour you'll hear from, I think, Bill Press, the Vice-Chair of PCAST, which I think is going to be a really interesting conversation. I'd encourage you all, the public or the workgroup, to participate and listen in.

Thank you, everybody. As you know, we will continue to work on this and move forward quickly and we will reconvene this group by the end of the month.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good-bye.

Judy Sparrow – Office of the National Coordinator – Executive Director
Good-bye.